Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY PUBLIC

October 22, 2025

[redacted]
914 W MARKET STREET OPERATING COMPANY LLC
[redacted]

RE: AUTUMN HOUSE OF YORK
914 WEST MARKET STREET
YORK, PA, 17401
LICENSE/COC#: 33822

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/20/2025, 08/21/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *AUTUMN HOUSE OF YORK* **License #**: *33822* **License Expiration**: *06/26/2026*

Address: *914 WEST MARKET STREET, YORK, PA 17401*

County: *YORK* **Region**: *CENTRAL*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *914 W MARKET STREET OPERATING COMPANY LLC*

Address: [redacted]

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *04/27/2000* **Issued By**: *Department of Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *120* **Waking Staff**: *90*

Inspection Information

Type: *Partial* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Complaint, Interim* **Exit Conference Date**: *08/21/2025*

Inspection Dates and Department Representative

08/20/2025 - On-Site: [redacted]

08/21/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *132* **Residents Served**: *91*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Laurel Court* **Capacity**: *20* **Residents Served**: *14*

Hospice

Current Residents: *16*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *90*

Diagnosed with Mental Illness: *13*

Diagnosed with Intellectual Disability: *1*

Have Mobility Need: *29*

Have Physical Disability: *3*

Inspections / Reviews

08/20/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/21/2025*

Inspections / Reviews *(continued)*

09/30/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *10/21/2025*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *10/06/2025*

10/07/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *10/21/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *10/21/2025*

10/22/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *10/21/2025*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted], resident [redacted] pulled resident [redacted] out of a chair by [redacted] arms. The home did not report this incident to the Department until [redacted]

Plan of Correction ***Accept ([redacted] - 09/23/2025)***

• Post-incident on 7/18/25 the med tech on duty placed an immediate phone call notification to the Area Agency on Aging, and notified all parties involved. Both residents were assessed by the Med Tech on duty with no further treatment needed. A reportable incident form was completed and faxed to the Department on 7/21/25.
• An audit of all other reportables for the month of July and August 2025 was completed by the Administrator on 9/1/2025 with no other reportables identified as being sent to the Department outside of the 24-hour timeline requirement.
• The administrator re-educated staff regarding the importance of reportable incidents being completed per 2600.16c on 9/17/2025 at the monthly staff meeting, where all violations related to the 8/20/2025 survey were discussed and education provided.
• An audit of incidents will be completed monthly for three months beginning 10/1/2025 by the administrator or designee to ensure all reportable incidents are submitted to the department within a 24-hour timeframe going forward. The results of these audits will be kept by the administrator for quality assurance purposes.

Licensee's Proposed Overall Completion Date: *10/01/2025*

Implemented [redacted] - 10/22/2025)

42b - Abuse

2. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [redacted] at 9:15 PM, resident [redacted] slapped resident [redacted] in the face. Resident [redacted] then grabbed resident [redacted] and pushed [redacted] away. Resident [redacted] had a red mark on [redacted] face where [redacted] had been hit.

On [redacted] at 4:06 PM, resident [redacted] pushed resident [redacted] as resident [redacted] was trying to leave the dining room. Resident [redacted] fell back and hit [redacted] head. Resident [redacted] had hematoma on the back of [redacted] head and complaints of back pain.

On [redacted] at 8:45 PM, resident [redacted] was in resident [redacted]s bedroom. Resident [redacted] asked resident [redacted] to leave the room. Resident [redacted] pushed resident [redacted] causing [redacted] to fall and hit [redacted] head. Resident [redacted] had a red mark on [redacted] left eyebrow and complained of head and back pain.

On [redacted] at 9:00 PM, resident [redacted] pulled on resident [redacted] arms to remove resident [redacted] from a chair resident [redacted] was previously sitting in.

42b Abuse (continued)

Repeated Violation [redacted] et al.

Plan of Correction ***Accept [redacted] - 10/07/2025)***

• Resident [redacted] is being issued a 30 day notice by administration on 9/22/2025 after other interventions have continued to be unsuccessful to prevent resident to resident incidents involving this resident. Memory Care Coordinator discussed with resident's POA on 9/18/2025 to possibly change to an in house PCP for better health and behavioral management.

• Resident [redacted] was sent to the hospital on 9/2/2025, returned to the facility on 9/4/2025 with med changes.

• Resident [redacted] no longer resides at the facility and was discharged as of 7/31/2025.

• Re education provided to all staff present (including med techs and PCAs) at monthly staff meeting on 9/17/2025 by Bayada Hospice entitled "Tips for Managing Patients with Dementia". On 9/17/2025, at scheduled monthly staff meeting, administrator discussed all violations related to the 8/20/2025 survey with staff present and provided education. Re education related to resident to resident incidents and staff interventions will be provided to nursing staff (including med techs and PCAs) by the Director of Wellness and Resident Care Coordinator on 9/24/25. Dementia trainings were held on 9/10/25 and 9/18/25 by Good News Consulting to give further resources and support for staff to assist residents on the secured dementia care unit. All staff (including med techs and PCAs) were scheduled to attend.

• An audit will be conducted by the administrator or designee monthly beginning 10/1/2025 for three months to review all resident to resident incidents from the previous month, if applicable, which will include making sure any involved resident's RASPs are up to date with behavioral concerns and interventions which would assist staff to best attempt to prevent incidents. These audits will also assess the residents' involved supervision needs to determine if the home can continue to meet the residents' needs. The results of these audits will be kept by the administrator for quality assurance purposes.

Licensee's Proposed Overall Completion Date: *10/15/2025*

Implemented [redacted] - 10/22/2025)

85a - Sanitary Conditions

3. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On [redacted] at 9:22 AM, a dead mouse was present on the south exit exterior landing leading to the rear driveway.

On [redacted] at 9:45 AM, mold spores were lining a ceiling vent in the 3000 hall near resident room [redacted]

On [redacted] at 9:51 AM, blood marks were present on the resident's mattress in resident room [redacted]

On [redacted] at 10:07 AM, a human molar was on the floor resident room [redacted]

On [redacted] the recliner in resident room [redacted] had a disposable pad with spots of feces present. Underneath the pad, the recliner was soiled with urine.

85a - Sanitary Conditions *(continued)*

Plan of Correction ***Accept [redacted] - 10/07/2025)***

• The dead mouse present on 8/20/2025 at the exterior of the building was removed by administration on 8/22/2025. The human molar was discarded immediately after being observed during time of survey on 8/20/2025 by housekeeping, room [redacted] was not occupied at the time of survey. The mattress in resident room [redacted] was replaced on 9/19/2025 by maintenance. The ceiling vent which showed mold spores in the 3000 hall was cleaned by housekeeping assigned to that hallway after it was identified at the time of survey on 8/20/2025. The resident in room [redacted] requires total physical assistance with all care needs and is heavily incontinent. The nursing and housekeeping staff are educated to dispose of incontinence pads and depends each time something is soiled, and to clean the room, change linens, etc as frequently as needed to eliminate odors and soiled materials. The director of wellness and resident care coordinator have discussed concerns of increased care needs with the resident's family and PCP and have requested an MA51 for a higher level of care be completed on 9/12/2025. The facility will assist the resident and their family with finding placement for a higher level of care and transition the resident as quickly as possible.

• An audit of the resident rooms was completed the week of 9/15/2025-9/19/2025 by the housekeepers assigned to each hallway and any other rooms identified as having compromised sanitary conditions were cleaned and/or reported to the housekeeping director for further intervention, this included looking at the mattress to ensure it was clean and in good repair.

• The administrator is obtaining a new pest control contract with another company as the current pest control contract does not seem to be proactive enough to prevent pests in the building and to ensure any pests that are identified in the building are eliminated in a timely manner. The current pest control contract is scheduled for twice monthly visits and will remain in effect until a new contract is obtained. The administrator discussed and re-educated staff to all of the violations identified in the 8/20/2025 survey including 2600.85a. Staff continue to be encouraged to report any pest and sanitation concerns to department directors and administration so issues can be addressed quickly and appropriately.

• An audit/walkthrough of the building will be completed by the housekeeping director or designee weekly for four weeks beginning 9/22/2025, then monthly for two months beginning November 2025 to monitor ongoing compliance with 2600.85a. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *10/15/2025*

Implemented [redacted] - 10/22/2025)

85b - Infestation

4. Requirements

2600.
85.b. There may be no evidence of infestation of insects or rodents in the home.

Description of Violation

On [redacted], there was evidence of a bedbug infestation in the home. At 9:43 AM, bedbug exoskeleton was observed in the bedframe and 2 dead bed bugs were observed by the closet and baseboard by the door in resident room [redacted] There were 2 dead bedbugs on the ground under the bed in resident room [redacted] and at 10:01 AM, two dead bedbugs were found next to the toilet in resident room [redacted]

On [redacted], there was evidence of a mouse infestation in the home. At approximately 10:20 AM a mouse was

85b - Infestation (continued)

running down the 3000 hall and entering a resident bedroom.

Plan of Correction ***Accept (10/07/2025)***

• Rooms and were not occupied at the time of the survey on 8/20/2025. Rooms , and 3121 had been heat treated by the pest control company on 8/6/2025 after bed bugs were identified in room The pest control company rechecked and treated room on 8/22/2025.

• A K-9 audit, which includes bed bug sniffing dogs, was scheduled and completed on 8/29/2025 and all areas, including common areas and resident rooms were checked to identify any active bed bug activity in the building. The report was sent to the pest control company and facility administration and any rooms identified with the K-9 alerting even if live activity was not found after further inspection were still scheduled for heat treatment with the pest control company. The heat treatment post K-9 audit of the entire facility was completed on 9/29/25 and 10/1/2025.

• The administrator is obtaining a new pest control contract with another company as the current pest control contract does not seem to be proactive enough to prevent pests in the building and to ensure any pests that are identified in the building are eliminated in a timely manner. The current pest control contract is scheduled for twice monthly visits and will remain in effect until a new contract is obtained. The administrator discussed and re-educated staff to all of the violations identified in the 8/20/2025 survey including 2600.85b. Staff continue to be encouraged to report any pest and sanitation concerns to department directors and administration so issues can be addressed quickly and appropriately. Maintenance places mouse traps in any areas when notified of mouse sightings and checks them daily for proper removal. The administrator and housekeeping director met on 9/30/2025 to discuss proper steps in preparing rooms for heat treatment to decrease the chance of spreading the infestation and also how to clean rooms after heat treatment to ensure dead bed bugs are removed properly after treatment moving forward. All housekeeping staff will be educated to this process by 10/10/2025 by the housekeeping director and administrator.

• An audit/walkthrough of the building will be completed by the housekeeping director or designee weekly for four weeks beginning 9/22/2025, then monthly for two months beginning November 2025 to monitor ongoing compliance with 2600.85b. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *10/15/2025*

Implemented (- 10/22/2025)

92 - Windows

5. Requirements

2600.

92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On at approximately 10:16 AM, the right-side window in resident room was open and not securely screened; the screen was loose and leaning against the window.

Plan of Correction ***Accept - 09/23/2025)***

• The screen in room was secured on 9/12/2025 by maintenance.

• An audit of the resident rooms was completed the week of 9/15/2025-9/19/2025 by the housekeepers assigned to each hallway and any other rooms identified as needing screens secured were reported to maintenance and will be

92 - Windows (continued)

fixed by 9/26/2025.

• Re-education was provided by administrator to new maintenance assistant on 9/12/2025 regarding regulation 2600.92. On 9/17/2025, at scheduled monthly staff meeting, administrator discussed all violations related to 8/20/2025 survey which included 2600.92 and the importance of all windows and screens being secure and in good repair.

• An audit/walkthrough of the building will be completed by the housekeeping director or designee weekly for four weeks beginning 9/22/2025, then monthly for two months beginning November 2025 to monitor ongoing compliance with 2600.92. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented (- 10/22/2025)

101j7 - Lighting/Operable Lamp

6. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident did not have access to a source of light that could be turned on/off by bedside.

Plan of Correction ***Accept (- 09/23/2025)***

• A lamp was placed at the bedside of resident on 9/12/2025 by administrator.

• An audit of the resident rooms was completed the week of 9/15/2025-9/19/2025 by the housekeepers assigned to each hallway with no other lamps identified as being missing at bedside.

• Re-education was provided by administrator to new maintenance assistant on 9/12/2025 regarding regulation 2600.101j that all bedrooms must have an operable lamp or other source of lighting that can be turned on at bedside. On 9/17/2025, at scheduled monthly staff meeting, administrator discussed all violations related to 8/20/2025 survey which included 2600.101j and the importance of resident's having a lamp at their bedside.

• An audit/walkthrough of the building will be completed by the housekeeping director or designee weekly for four weeks beginning 9/22/2025, then monthly for two months beginning November 2025 to monitor ongoing compliance with 2600.101j. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *09/23/2025*

Implemented (- 10/22/2025)

101o - Walls, Floors, Ceilings

7. Requirements

101o - Walls, Floors, Ceilings *(continued)*

2600.
101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

On [redacted] at 10:15 AM, the carpet in resident room [redacted] had a large water stain measuring approximately 6' x 6' resulting from a previous P-Tech leak.

Plan of Correction ***Accept [redacted] 09/23/2025)***

• The housekeeping director was notified of the carpet in room [redacted] needing shampooed on 9/12/2025 by administrator due to water leak from p-tac unit leak. Housekeeping cleaned carpet the same week and often cleans the carpet in this room due to frequent other stains related to incontinence and other spills.
• An audit was completed of all other resident rooms by the housekeeper's assigned to each hallway the week of 9/15/2025 through 9/19/2025 and any other carpets identified as needing cleaned or replaced were identified. Housekeeping team to clean any carpets identified as needing cleaned due to stains the week of 9/22/2025. Empty rooms were audited by the administrator and marketing liaison and a list was compiled for housekeeping of any carpets needing cleaned or replaced on 9/18/2025.
• Re-education was provided to staff at the scheduled monthly staff meeting on 9/17/2025 by the administrator to ensure any concerns with the cleanliness of resident rooms are reported in a timely manner so that carpets and other areas can be cleaned as quickly as possible.
• An audit/walkthrough of resident rooms will be completed by the housekeeping director or designee weekly for four weeks beginning 9/22/2025, then monthly for two months beginning November 2025 to monitor ongoing compliance with 2600.101o. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *09/23/2025*

Implemented [redacted] - 10/22/2025)

101r - Bedroom - shades/drapes/window covering

8. Requirements

2600.
101.r. There must be drapes, shades, curtains, blinds or shutters on the bedroom windows. Window coverings must be clean, in good repair, provide privacy and cover the entire window when drawn.

Description of Violation

The window blinds in resident room [redacted] were broken and not in good repair. On [redacted], at least 6 slats were broken and missing pieces.

Plan of Correction ***Accept ([redacted] - 09/23/2025)***

• A work order was placed on 9/12/2025 by the administrator for maintenance to replace the blinds in room [redacted]. The blinds were replaced on 9/17/2025 by maintenance.
• An audit was completed of all other resident rooms by the housekeeper's assigned to each hallway the week of 9/15/2025 through 9/19/2025 and no other issues were found with room blinds in occupied rooms. Empty rooms were audited by the administrator and marketing liaison and a list was compiled for maintenance of any empty rooms needing new blinds on 9/18/2025.
• Re-education was provided to all staff present at scheduled monthly staff meeting on 9/17/2025 by the

101r Bedroom shades/drapes/window covering (continued)

administrator to ensure any concerns with any items in need of repair are reported in a timely manner so a work order can be placed and the item can be fixed or replaced as quickly as possible for safety.

• An audit/walkthrough of the rooms with blinds will be completed by the housekeeping director or designee weekly for four weeks beginning 9/22/2025, then monthly for two months beginning November 2025 to monitor ongoing compliance with 2600.101r. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *09/23/2025*

Implemented [redacted] - 10/22/2025)

103g - Storing Food

9. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On [redacted] at 10:00 AM, two trays of red gelatin were opened and unsealed in the kitchen's walk in cooler.

Plan of Correction ***Accept [redacted] - 09/23/2025)***

• The two trays of red gelatin were identified by the dining director as being made by the PM cook from the previous day (8/20/2025) for a meal on 8/21/2025. The dining director reached out to the PM cook the morning of 8/21/2025 to address the concern of the uncovered gelatin and provided documentation to the DHS surveyor at the time the violation was identified.

• No other violations were identified in the kitchen at time of survey.

• Re education was provided to all present at the monthly staff meeting on 9/17/2025 by the administrator to ensure staff hear the importance of covering, labelling and dating food properly at all times for safety. At this time the administrator discussed and re educated staff on all violations identified during the 8/20/2025 survey.

• An audit/walkthrough of the kitchen will be completed by the dining director or designee weekly for four weeks beginning 9/22/2025, then monthly for two months beginning November 2025 to monitor ongoing compliance with 2600.103g. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *09/23/2025*

Implemented [redacted] - 10/22/2025)

183e - Storing Medications

11. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

A used insulin pen, prescribed for resident [redacted], was not labeled with the date it was opened.

183e - Storing Medications (continued)

Repeated Violation - [redacted], et al.

Plan of Correction ***Accept [redacted] - 09/23/2025)***

• Resident [redacted] insulin pen was labeled with the appropriate open date on 8/21/2025 after it was identified as not correctly labeled with an open date.
• Brockie Pharmacy completed an initial med cart audit on 9/19/2025 for all med carts; documentation will be provided to the facility for administration to use for QA and training purposes will be kept on file.
• Re-education will be provided to nursing staff (including med techs and PCAs) on 9/24/25 by Director of Wellness and Resident Care Coordinator. The administrator discussed the entire list of violations regarding the 8/20/2025 survey and re-educated on the importance of 2600.183e at the scheduled monthly staff meeting held on 9/17/2025.
• The Director of Wellness & Resident Care Coordinator will complete an audit on all med carts again on 10/16/2025, on a monthly basis for 3 months. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *10/16/2025*

Implemented ([redacted] - 10/22/2025)

184b - Labeling OTC/CAM

12. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On [redacted], several tubes of moisture barrier cream were in the main, shared shower room of the Secured Dementia Care Unit and were not labeled with residents' names.

Repeated Violation - [redacted] et al.

Plan of Correction ***Accept ([redacted] - 09/23/2025)***

• Cubicles were purchased by the administrator on 8/21/2025 at time of survey and were delivered on 8/22/2025. These cubicles were placed in the linen closet so that all residents residing on the secured dementia care unit will have their own cubicle where their toiletry items can be kept locked away. The tubes of barrier cream identified in the main, shared shower room of the Secured Dementia Care Unit on 8/20/2025 were discarded by the administrator and replaced, ensuring all OTC items replaced were labeled with each individuals name on them.
• Brockie Pharmacy completed an initial med cart audit on 9/19/2025 for all med carts; documentation will be provided to the facility for administration to use for QA and training purposes will be kept on file.
• Re-education will be provided to nursing staff (including med techs and PCAs) on 9/24/25 by Director of Wellness and Resident Care Coordinator. The administrator discussed the entire list of violations regarding the 8/20/2025 survey and re-educated on the importance of 2600.184b at the scheduled monthly staff meeting held on 9/17/2025.
• The Director of Wellness & Resident Care Coordinator will complete an audit on all med carts again on 10/16/2025, on a monthly basis for 3 months. The Memory Care Coordinator will conduct a weekly audit of the secured dementia care unit beginning 9/22/2025 for four weeks, then monthly for 3 months beginning November 2025 to ensure all OTC items are labeled properly and kept in the new cubicle storage for each resident. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Proposed Overall Completion Date: 10/06/2025

184b - Labeling OTC/CAM *(continued)*

Licensee's Proposed Overall Completion Date: *10/16/2025*

Implemented (10/22/2025)

185a - Implement Storage Procedures

13. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On , the cap to resident was not tightened, resulting in the plastic bag containing the bottle to be saturated with the medication.

Resident is prescribed tab, 2 tablets by mouth every 6 hours as needed. On , the medication was not available in the home.

Resident is prescribed blood sugar tests before meals and at bedtime. The blood glucose checks on the glucometer did not match the numbers transcribed on the resident's August 2025 Medication Administration Record (MAR) as follows:
reading on at 5:10 AM was -the blood sugar level was not documented on the MAR.
reading on at 6:44 PM was -the number documented in the MAR was .

Repeated Violation - , et al.

Plan of Correction ***Accept (- 10/07/2025)***

• The Lorazepam bottle for Resident was reordered and replaced by the Resident Care Coordinator on 9/4/2025. Acetaminophen for resident was also ordered at that time. Resident no longer lives at the facility and was discharged on 8/23/2025.
• An audit of all August 2025 MARs was conducted by the Resident Care Coordinator on 9/9/2025. Any concerns noted were documented and each med tech involved was counseled and re-educated one-on-one with the Resident Care Coordinator, counseling occurred on several dates including 9/18/25 & 9/19/25. The Resident Care Coordinator will ensure that each diabetic resident that has blood glucose checks ordered will have a glucometer audit listed on their MAR for staff to complete monthly by 9/19/2025.
• The administrator, Director of Wellness and Resident Care Coordinator met with Brockie Pharmacy on 9/10/2025 and a new communication between the pharmacy and nurse management will take place that the pharmacy will email updates for anything the pharmacy receives orders/refills for where a resident does not use them or any other fill concerns that would cause a resident not to get the medication as ordered. Brockie Pharmacy conducted audits on all medication carts on 9/19/2025, documentation of audits will be submitted to and kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.
• The director of wellness and resident care coordinator held a nursing staff meeting (including med techs and PCA's) on 8/28/2025 and discussed the importance of 2600.185a. The administrator discussed and re-educated all staff present at the monthly staff meeting on 9/17/2025 all violations identified during the 8/20/2025 survey. The Director of Wellness and Resident Care Coordinator will hold a nursing staff meeting (including PCAs and med techs) on 9/24/2025 where re-education on 2600.185a will take place again. All med techs were scheduled previously to receive Diabetic Re-education Certification by Wellspan on 9/29/25 and 10/6/25 which will further educate on the importance of documenting glucometer results to the MAR accurately. Bayada is also scheduled to provide

185a - Implement Storage Procedures (continued)

additional diabetic education to nursing staff (med techs and pcas) at the 9/24/2025 nursing staff meeting held by the Director of Wellness and Resident Care Coordinator.

• The resident care coordinator will audit 15% of resident MARs weekly for four weeks beginning the week of 9/22/2025 and then monthly for three months beginning November 2025. The Director of Wellness and Resident Care Coordinator will conduct an audit on all medication carts again beginning on 10/16/2025, monthly for 3 months. The Resident Care Coordinator or designee will audit the scheduled staff glucometer audit sheets weekly for four weeks beginning 9/26/2025 and then monthly for 3 months beginning in November 2025. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *10/15/2025*

Implemented (- 10/22/2025)

187b - Date/Time of Medication Admin.

14. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident was prescribed , apply to perineal twice daily. The resident's August 2025 Medication Administration Record (MAR) did not include the staff member's initials who administered the medication on and at 3:00 PM.

Resident # was prescribed , 2 tablets by mouth twice daily. On this medication was not available in the home. Staff interviews and resident August 2025 MAR indicated this medication has not been available in the home since . However, the resident's August 2025 MAR documents the administration of the medication on at 8:00AM, at 8:00 AM and 5:00 PM.

Resident was prescribed take 1 tablet by mouth once daily, take 1 tablet by mouth in the morning before breakfast and blood sugar tests before meals and at bedtime. The resident's August 2025 MAR did not include the staff member's initials who administered the medications on at 6:00 AM.

Plan of Correction ***Accept - 10/07/2025)***

• An audit of all August 2025 MARs was conducted by the Resident Care Coordinator on 9/9/2025. Any concerns noted were documented and each med tech involved was counseled and re-educated one-on-one with the Resident Care Coordinator on various dates including 9/18/25 & 9/19/25. The Resident Care Coordinator will ensure that each diabetic resident that has blood glucose checks ordered will have a glucometer audit listed on their MAR for staff to complete monthly by 9/19/2025.

• The administrator, Director of Wellness and Resident Care Coordinator met with Brockie Pharmacy on 9/10/2025 and a new communication between the pharmacy and nurse management will take place that the pharmacy will email updates for anything the pharmacy receives orders/refills for where a resident does not use them or any other fill concerns that would cause a resident not to get the medication as ordered. Brockie Pharmacy conducted audits on all medication carts on 9/19/2025, documentation of audits will be submitted to and kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

• The director of wellness and resident care coordinator held a nursing staff meeting (including med techs and

187b - Date/Time of Medication Admin. (continued)

PCA's) on 8/28/2025 and discussed the importance of 2600.187b. The administrator discussed and re-educated all staff present at the monthly staff meeting on 9/17/2025 all violations identified during the 8/20/2025 survey. The Director of Wellness and Resident Care Coordinator will hold a nursing staff meeting (including PCAs and med techs) on 9/24/2025 where re-education on 2600.187b will take place again. All med techs were scheduled previously to receive Diabetic Re-education Certification by Wellspan on 9/29/2025 & 10/6/2025 which will further educate on the importance of documenting glucometer results to the MAR accurately. Bayada is also scheduled to provide additional diabetic education to nursing staff (med techs and pcas) at the 9/24/2025 nursing staff meeting held by the Director of Wellness and Resident Care Coordinator.

• The resident care coordinator will audit 15% of resident MARs weekly for four weeks beginning the week of 9/22/2025 and then monthly for three months beginning November 2025, these audits will include all MAR documentation and will look for patterns i.e. a med be signed off as given but had previously been unavailable, etc. The Director of Wellness and Resident Care Coordinator will conduct an audit on all medication carts again beginning on 10/16/2025, monthly for 3 months. The Resident Care Coordinator or designee will audit the scheduled staff glucometer audit sheets weekly for four weeks beginning 9/26/2025 and then monthly for 3 months beginning in November 2025. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *10/15/2025*

Implemented ([redacted] - 10/22/2025)

187c - Refusal of Medication

15. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

On [redacted] at 9:00 AM and 2:00 PM, resident [redacted] refused to take a scheduled doses of [redacted] The home did not report the refusals to the prescriber.

Plan of Correction ***Accept [redacted] - 10/07/2025)***

• Resident [redacted] PCP was notified by the Director of Wellness and Resident Care Coordinator on 9/2/2025 when they met to discuss refusals, behaviors and other health related concerns. The Resident Care Coordinator updated the current Medication Refusal Form, on 9/18/2025, which all med techs should complete and submit to any resident's PCP after a refusal occurs.

• An audit of all August 2025 MARs was conducted by the Resident Care Coordinator on 9/9/2025. Any concerns noted were documented and each med tech involved was counseled and re-educated one-on-one with the Resident Care Coordinator on various dates including 9/18/2025 & 9/19/2025.

• The administrator discussed and re-educated all staff present at the monthly staff meeting on 9/17/2025 all violations identified during the 8/20/2025 survey. The Director of Wellness and Resident Care Coordinator will hold a nursing staff meeting (including PCAs and med techs) on 9/24/2025 where re-education on 2600.187c will take place again and med techs will be re-educated to the Medication Refusal Form that must be completed and submitted to a resident's PCP after refusals.

• The resident care coordinator will audit 15% of resident MARs weekly for four weeks beginning the week of

187c - Refusal of Medication (continued)

9/22/2025 and then monthly for three months beginning November 2025, at this time Medication Refusal Forms will be matched to the MAR to ensure any refusals have been documented appropriately and sent to the PCP. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *10/15/2025*

Implemented [redacted] - 10/22/2025)

187d - Follow Prescriber's Orders

16. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident [redacted] was prescribed [redacted] mouth every 6 hours and [redacted] take 0.25mL by mouth every 4 hours. This medication was not administered from [redacted] at 12:00 PM - [redacted] at 8:00 AM as the medication was not available in the home.

Resident [redacted] was prescribed [redacted], take 1 capsule by mouth at bedtime. This medication was not administered from [redacted] through [redacted] as the medication was not available in the home.

Repeated Violation - [redacted] et al.

Plan of Correction ***Accept [redacted] - 10/07/2025)***

• During this time, 8/6-19/2025 the nursing staff called Brockie pharmacy for resident [redacted]s [redacted] to be refilled and were informed that [redacted] was on backorder from the pharmacy. Director of Wellness called to discuss with Pharmacy on 8/21/2025, the [redacted] was delivered and available on 8/19/2025. Previously resident [redacted] has called Brockie pharmacy and told them they are not to fill [redacted] medications. Director of Wellness called and informed pharmacy with resident and family permission that the pharmacy should be filling resident [redacted]s medications from that point forward on 8/22/2025.

• The administrator, Director of Wellness and Resident Care Coordinator met with Brockie Pharmacy on 9/10/2025 and a new communication between the pharmacy and nurse management will take place that the pharmacy will email updates for anything the pharmacy receives orders/refills for where a resident does not use them or any other fill concerns that would cause a resident not to get the medication as ordered. Brockie Pharmacy conducted audits on all medication carts on 9/19/2025, documentation of audits will be submitted to and kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations. The Resident care coordinator audited all August 2025 MARs and identified concerns with documentation or medications not available, all med techs with noted concerns were counseled and re-educated one-on-one by the resident care coordinator on various dates including 9/18/2025 & 9/19/2025 . The Administrator will review and update the policies and procedures related to medication storage and availability to include contacting the resident's physician for recommendations or hold orders until a medication becomes available. This will be completed by 10/10/2025 and all med techs will be educated to the updated policy by 10/15/2025.

• The director of wellness and resident care coordinator held a nursing staff meeting (including med techs and PCA's) on 8/28/2025 and discussed the importance of 2600.187d for safety reasons. The administrator discussed and re-educated all staff present at the monthly staff meeting on 9/17/2025 all violations identified during the 8/20/2025

187d - Follow Prescriber's Orders (continued)

survey. The Director of Wellness and Resident Care Coordinator will hold a nursing staff meeting (including PCAs and med techs) on 9/24/2025 where re-education on 2600.187d will take place again.

• The resident care coordinator will audit 15% of resident MARs weekly for four weeks beginning the week of 9/22/2025 and then monthly for three months beginning November 2025. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *10/15/2025*

Implemented [redacted] - 10/22/2025)